12. INCLUSION OF FAMILY PLANNING SERVICES IN *SOONERCARE*

Introduction

This section of the operational protocol describes Oklahoma's process for including family planning services in *SoonerCare*, with specific emphasis on Title X providers and service accessibility for adolescents.

Inclusion of Title X Providers

The Oklahoma State Department of Health (OSDH) is the Title X agency for the State. Title X funding is currently used to provide services through health department clinics operated by OSDH and through a number of other public and private entities which operate programs under contracts or inter-agency agreements with the Health Department. These entities include: the Tulsa and Oklahoma City-County Health Departments; several community health centers, including Variety Health Center sites in Oklahoma City and Midwest City; the Neighborhood Services Organization and the Southeast Area Health Center in Oklahoma City. OSDH also contracts with counties to deliver services through their public facilities; and, contracts with a number of other private providers.

Under the State's 1915(b) program, a number of Title X providers have been classified as "traditional providers" and so have received special status with respect to contracting. Specifically, MCOs are required (and will continue to be required under the 1115(a) program) to offer contracts to all traditional providers at equivalent terms to what is offered to non-traditional providers. Through this mechanism, a large number of Title X providers have become part of the MCO networks, with most participating in more than one. Several non-Title X family planning clinics (e.g., Planned Parenthood) were also included in the traditional provider lists and, as a result, are now serving in health plan networks.

Service Accessibility for Adolescentg

Under the demonstration, health plans will not be permitted to network restrict adolescents to network providers for family planning services. Adolescents residing in health plan service areas will be able to select any qualified family planning provider, whether or not the provider operates within a network. Adolescents residing in partial capitation areas will be able to obtain family planning services from any urban or rural Title X provider without authorization from the primary care physician. These options for adolescents will be described in all appropriate health plan literature (e.g. member handbooks) as well as literature produced by the State for rural beneficiaries.

As described in sections **3 and 4** of this document, the State will reimburse out-of-network family planning providers on a fee-for-service basis and will deduct the amount paid from future capitation payments. Section **4** of the protocol defines the precise family planning benefit package for ***Soonercare*** enrollees.

13. PROCESS FOR FINANCIAL REPORTING

Introduction

This section of the operational protocol discusses ***SoonerCare*** financial reporting processes. The first part describes the manner in which the State will report program expenditures to HCFA. The second part describes the State's approach to collecting financial data from MCOs and monitoring their solvency.

Reporting to HCFA

The Division of Finance is directly responsible for all federal reporting requirements. This division consists of personnel specifically identified for this reporting, including a Federal Programs Specialist, a Claims Payment/Accounting Clerk, and a MMIS Claims Analyst.

Waiver-specific expenditures, are detailed on separately identified Form HCFA-64's (64.9) for reporting purposes to not only designate quarterly periods, but also fiscal year periods as well. The waiver-specific expenditures as reported on the separate forms are also identified by the HCFA-assigned ID number or the demonstration project number.

The administrative costs associated with specific waivers are identified on a separate Form HCFA-64 (64.10), and these expenditures are applicable to the certified matching funds. All State/Local certified monies used as matching funds to specific waiver costs are exempt from other Medicaid purposes as provided for by federal law.

Because the State is not creating new categories of eligibles, it believes that, in most cases, existing standard mechanisms for financial reporting will be largely sufficient to monitor the program. In addition, the State will prepare a yearly report that compares expenditures under the demonstration to the upper payment levels agreed to with HCFA so that overall budget neutrality can be demonstrated. The State is prepared to collaborate with HCFA to develop any other reporting changes that are needed to support program monitoring.

MCO Financial Monitoring

The State has developed a set of guidelines for collecting financial data from MCOs and monitoring their performance against a schedule of financial ratios. MCOs are required to submit quarterly financial statements and audited annual financial statements pursuant to GAAP standards. This financial information is reviewed by State staff against standards derived from the **1993** HCIA Guide to the Managed Care Industry.

The key financial ratios being examined include:

- Administrative Cost Ratio
- Inpatient Expense per member per month
- Administrative Expense per member
- Medical Loss Ratio per month
- Current Ratio
- Net Worth per member per month
- Days in Receivables
- Other Revenue per member per month
- Health Care Revenues per member
- Total Patient Days per month
- Pretax Income per member per month

If MCOs are found to be out-of-compliance with any standards and in a potentially weak financial position, the State is empowered under its contract to require that financial reports be submitted on a monthly basis. Should a plan's financial status prove to be at a level that jeopardizes its ability to comply with all contract standards, the State has contingency plans in place to intervene on the members' behalf. These contingency plans are described in section 14.

14. CONTINGENCY PLANS IN THE EVENT OF MCO CONTRACT TERMINATION OR INSOLVENCY

Introduction.

This section describes the State's contingency plans for cases in which MCO contracts are terminated or they become financially insolvent. In addition, the section addresses termination of PCCM contracts in rural areas.

MCO Contract Termination or Insolvency

Oklahoma has built in safeguards to the ***SoonerCare*** system that, coupled with diligent ongoing effort, should greatly reduce the chances of MCO contract termination or insolvency. In the event that a Health Plan or Outpatient Network does suffer financial or other problems that make contract termination a possibility, the State will know about the trouble far in advance of crisis, and will attempt corrective action with the MCO to address the potential problem. Should this not be sufficient, the State will be able to put its termination contingency plans into early action to assure a minimal disruption to the ***SoonerCare*** members and the system as a whole. All the safeguards and contingency plans described for Health Plans are applicable also to Outpatient Networks.

During the procurement and contracting process, the bidding Health Plans are required to submit complete financial reports along with their technical proposals. These reports are checked and analyzed, not only by the State bid evaluation team, but by the actuarial firm (Coopers & Lybrand) hired to assist the State in the rate setting and procurement process. Once program operations begin, the State will actively monitor Health Plan activities in a number of ways, including: 1) production and review of standardized reports, documenting utilization patterns, member satisfaction, member disenrollment, and financial solvency (see section #13, for financial reporting standards); 2) operation of a toll-free member services line, through which Health Plan members can register complaints directly with the State; and, 3) periodic on-site operational and financial audits of each Plan to be performed directly by the State.

The Health Plan contracts in the urban areas under the 1115(a) demonstration, as well as the current 1915(b) waiver, contain a variety of ongoing monitoring and safeguards. In addition to the periodic financial and performance reporting, Health Plans are required to send to the Health Care Authority copies of all filings, reports and other documentation submitted to the Oklahoma State Department of Health, the MCO licensing agency. Any action taken by the licensing agency against a Health Plan will be communicated to the Authority by the Health Department. The ***SoonerCare*** MCO contract also requires compliance with all Health Department financial standards for HMOs, even for those Public Managed Care Plans not licensed through the Health Department.

In circumstances where a Health Plan is found to be out of compliance with program standards, the State will have the authority to impose monetary sanctions and/or terminate its contract. The State will also require each participating ***SoonerCare*** Health Plan to post a performance bond in an amount equal to the estimated maximum monthly capitation payment made to that Plan. This performance bond will be forfeited and used to pay the costs of any damages incurred by the State in the case of contract termination.

In the case of contract termination for insolvency or default, the ***SoonerCare*** MCO contract sets out the procedures that a Health Plan must follow. The contract provisions for the procedures upon termination state that the Health Plan must:

- Stop work under the contract on the date and to the extent specified in the Notice of Termination.

- With the approval of the, State, settle all outstanding liabilities and all claims arising out of such termination of orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provision of the contract.

- Complete the performance of such part of the work as has not been terminated by the Notice of Termination.

- Provide all necessary assistance to the State in transitioning members out of the Health Plan and into another, to the extent specified in the Notice of Termination. Such assistance shall include, but not be limited to, the forwarding of medical and other records; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized and pregnant members in their last four weeks of pregnancy.

- Provide to the State on a monthly basis, until instructed otherwise, a monthly claims aging report by provider/creditor that includes Incurred but not Received (IBNR) claim amounts; a monthly summary of cash disbursements; and copies of all bank statements received by the Health Plan in the preceding month. Such reports will be due on the fifth (5th) business day of each month for the prior month.

Should a Health Plan experience financial or performance problems that jeopardize its ability to carry out its responsibilities to the ***SoonerCare*** program, the State will communicate with the Health Plan regarding possible corrective action. The Plan will be given a timeline for the correction, with a potential termination date set after a reasonable period. Should the Plan fail to correct the problem, the State will send out a Notice **of** Termination to the Plan, stating the effective date and terms for the contract termination. The State's contingency plans will then be activated.

In the unlikely event that a Health Plan files for bankruptcy protection or is placed under receivership with no prior notification to the State, termination may be effected as of the day of the occurrence. The State could then disenroll all members of the Plan as of the contract termination, if in the best interests of the ***Soonercare*** program. Timing of this disenrollment may necessitate that members be placed in the fee-for-service system for the period until their enrollment in another Plan takes effect. This period of time should not exceed six weeks at a maximum, and the State will work to ensure that all needed medical care is received during this interim.

The Oklahoma MMIS system has been programmed to enable the State to run a batch disenrollment of all members of a terminated Health Plan, and auto-assign the members to the remaining Plans in the area, with a single overnight computer run. Members will be notified immediately of the change and the effective date, and will be allowed to change Plans within the first thirty **(30)** days **of** their enrollment with the new Health Plan, according to the MCO contract guidelines. Should there be inadequate capacity in a given area upon a Plan's termination, the auto-assignment algorithm will cut off at the total system capacity, and the remainder of the Medicaid recipients will revert to the fee-for-service system available in the area. The State considers such scenarios in setting the overall capacity requirements for each area covered by the Health Plans, making such a situation extremely unlikely.

To facilitate the transition of ***Soonercare*** members in the event of contract termination or insolvency, the State will assign a "crash team" of key personnel to assist in the process. This team will consist of: the Business and Contracts Manager, the Chief Information Officer, the Director of Managed Care, the Managed Care Enrollment Manager, a Managed Care Financial Analyst, the Medical Director and the General Counsel. These people, their staffs and designees, will coordinate all aspects of the transition of the members to other Plans. Details such as the transfer of medical records, the continuation of ongoing treatments and the identification of pregnant women and other patients with special needs will be prioritized and assigned to the appropriate personnel for immediate action.

The State team will meet with their functional counterparts from the troubled Health Plan to draft out the detailed priorities and assignments, according to the individual situation. Circumstances such as the size of the Health Plan, the capacity of other Plans in the area, the timing and the type of trouble may necessitate different approaches to the problems. All appropriate personnel from both the State and the Health Plan will be called upon to assist in the transition effort. Should a situation arise where the Health Plan personnel require assistance in the transition, the State may need to place certain of its personnel in the Health Plan to carry out specific duties. The State may also be required to hire outside expert help in certain circumstances. These costs would be paid for by the defaulting Health Plan, or the Plan's performance bond proceeds.

Termination of PCCM Contracts

In the rural areas, under the PCCM model, termination of a provider contract will not have the same far-reaching effect as with the MCO contracts in the urban areas. In the event an individual Primary Care Case Management contract is terminated, the members enrolled with that PCCM may be given the opportunity to choose or be assigned to a new provider in the area before the effective date of termination. This will be the case where there is adequate advance notice of the contract termination, such as the forty-five (45) day notice required in the PCCM contracts.

If, for whatever reason, the PCCM contract is terminated with inadequate advance notice, the State will disenroll the ***SoonerCare*** members effective the date of the contract termination. These members will receive care through the fee-for-service system until their new PCCM enrollments take effect. This fee-for-service window should, in no event, be longer than six weeks. During the period of transition, including any fee-for-service window, the State will work with the providers to ensure a smooth transition for the ***SoonerCare*** members.

15. RECIPIENT COMPLAINTS AND GRIEVANCES

Introduction

This section of the protocol document describes the processes which will be employed by the Oklahoma Health Care Authority to consider grievances of members in the urban MCOs' as well as members enrolled in the rural primary care physician case managers.

Overview

Under Oklahoma law, the Oklahoma Department of Human Services (DHS) is the Oklahoma Health Care Authority's (OHCA's) contracted agent for the determination of eligibility. *63* Okla. Stat. § 5009 (B)(1)(Supp. 1994). Because of this contractual agreement, all hearings requested by members in the waiver who have complaints regarding eligibility have an evidentiary hearing before a hearing examiner at DHS. A copy of DHS's policy regarding hearings is attached as Attachment 13.

Processing of Complaint

Beneficiaries making complaints to the Authority may do so in three ways.[4] The member may level a complaint by telephone, by letter or facsimile or may make a walk in complaint.

If a complaint is levied by telephone, Authority staff will log the call and mail the appropriate form to the member. Form LD-1 is the form for a member grievance (see Attachment 14). Form LD-2 is the form for a provider grievance (see Attachment 15). The same day the complaint is made, a letter will be sent to the member or provider and will have the time limits for filing an appeal. When the complaint is made, the caller will be verbally advised that a grievance or appeal must be filed within twenty (20) days of the offending action. Authority staff will also verbally inform the caller that they may receive assistance in completing the form, if the caller needs assistance. The caller will be given the name of appropriate staff or the docket clerk for assistance. If the caller is a member of an MCO, they will be advised that the MCO should resolve their complaint unless the complaint involves a danger to life or health and safety in which case the Authority will directly intervene. In the case the complaint should be handled by the

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[3] The acronyms HMO's and MCO's, managed care organizations, will be used interchangeably in this document. The term HMO shall include appeals regarding a subcapitated models OHCA develops such as outpatient networks.

[4] We use the word complaint at this stage because we do not know if the issue is appealable or one which can or should be resolved by the HMO or PCP/CM.

MCO, the Authority will send the LD-1 and once the complaint is received will forward the complaint to the MCO.

If a request is sent by letter, the letter will be logged in by computer, an LD-1 or LD-2 will be sent and the sender will be asked to complete the form. However, with the receipt of the letter, the timeliness requirement of the appeal will be met.

Facsimile requests may also be sent to trigger the process. The process for starting an appeal by facsimile will be consistent with a letter appeal. Timeliness requirements are met by its receipt but senders will be sent the LD-1 and LD-2 for completion in twenty (20) days. Facsimiles may only be received from 8:00 a.m. to 5:00 p.m. to be recorded on the same business day. Any facsimile received after 5:00 p.m. will be recorded the following day, unless the next day is a Saturday, Sunday or legal holiday. In this case, it shall be recorded as received on the first day which is not a Saturday, Sunday or legal holiday.

As an additional precaution for access to the appeal process, all DHS county officials will have copies of forms LD-1 and LD-2's for distribution. Also, because the Authority does not know where each call regarding a complaint will be received, all client relations and managed care staff will be trained to handle incoming calls as described above.

Once an LD-1, LD-2 letter or facsimile is received, the docket clerk in the Legal Division of the Authority will stamp the document as received. The docket clerk will then determine whether the grievance will receive a Subchapter 1, Subchapter 2, or Subchapter 3 hearing. If the clerk determines that the client is a member of an MCO or PCP/CM and the MCO or PCP/CM has not had an opportunity to address the complaint (assuming the complaint is not a danger to life or safety), the clerk will then mail the complaint to the MCO or PCP/CM with a cover letter requesting the MCO or PCP/CM address the grievance. In the Authority's contracts with MCO's, paragraph 2.16. requires each MCO to have an informal grievance process. In the Authority's contract with the PCP/CM, paragraph 3.6, the PCP/CM will be required to attempt to resolve a grievance in an informal manner.

After making the determination about the placement of the appeal, a file will be created for the appeal, a hearing date will be docketed and a memorandum drafted to the appropriate division advising the division personnel of their responsibility to prepare for a hearing on the date scheduled (see Attachment 16). The memorandum will list a prehearing date by which the division must complete a *summary* of information and a list of witnesses and exhibits for tier 2 of Subchapter 1 hearings and for all Subchapter 2 hearings.[5] The appellant will be sent a *summary* which will include witness and exhibit lists.

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[5] Subchapter 1 hearing is the process for appeals by members. It is described fully below but it has two tiers or levels of review. The first is a review by three members of the Authority. This panel may do a paper review or meet with the client. The second tier or

After the memorandum is drafted, the docket clerk will send a letter to the appellant advising of the appeal date and of the applicable subchapter that applies to the appeal (see Attachment 17). A copy of the appeals policy will be included in the letter. In cases of rescheduling, another letter will be sent stating the new hearing date.

In addition to the responsibility of the docket clerk, the receiving division or unit has responsibilities regarding the appeal. In the case an appeal reaches the second tier for a member appeal or in the case of a provider appeal, the receiving unit at the Authority is responsible for preparing a hearing summary. The hearing summary will include the decision letter which prompted the appeal, the applicable Authority rule, federal regulation or statute relied upon for the decision, any applicable correspondence (including medical records), a list of persons who can explain the decision made, relevant documents that explain the decision and a narrative summary of the case.

Member/Beneficiary Appeals

Shifting from the administrative work processing the appeal to the actual process conferred during the appeal, the Authority will supply members a two tiered process for those appeals which relate to the scope of services, covered services, wrap around services, or complaints regarding service or care. This two tiered review is called a Subchapter 2 proceeding. The first tier is a panel review. The second tier is an evidentiary hearing. Subchapter 2 proceedings will also be given for those remaining in the fee for service system who are denied prior authorizations.

The first step in the Subchapter 2 proceeding is to offer **a** "Program Panel" review of the appeal. The "Program Panel" will be composed of three agency employees to hear the case. The panel will be comprised of the agency's Medical Director, who will serve as the chairperson, a person in the division involved in the appeal **(i.e.** an appeal complaining about incorrect enrollment in an MCO would involve the agency's Managed Care Division), and a person from a division designated by the Medical Director.

The Program Panel may conduct a paper review or conduct a personal interview of the member. **A** written decision must be issued within thirty **(30)** days of the date the agency is in receipt of the LD-1. The decision letter will be issued by the Medical Director and shall contain a summary of the complaint and the reasoning of the panel in making their decision. If the decision is adverse to the Managed Care Provider, a letter detailing the remedial actions to be taken by the provider will be sent to the Provider. A copy of the decision will be sent to the parties outlining the right to appeal the decision of the Program Panel. Any appeal of the Panel decision must be instituted within fifteen (1*5)* days of the mailing of the decision letter, A copy of the decision letter is mailed to the docket clerk.

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level of review is an evidentiary hearing with an administrative law judge. A subchapter 2 hearing is a hearing with an administrative law judge.

In the case a member is unhappy with the Program Panel's decision, a timely appeal may ensue from the "Program Panel's" decision. This second tier hearing will be conducted by an administrative law judge. The hearing by the administrative law judge (ALJ) will be conducted in accordance with the federal regulations found at 42 C.F.R. $431.240-224 (Oct. 1,1994). The hearing conducted by the ALJ will be held in an informal manner without the use of formal rules of evidence or procedure. During the second tier of the Subchapter 2 proceeding, the ALJ shall have the power to hold prehearing conferences, consider any matter to expedite the hearing, require the parties to state their positions, require the parties to produce relevant witnesses and documents under their control, rule on motions and other procedural matters, regulate the course of hearings, establish time limits for the submission of motions and memoranda, take judicial notice of material facts and administer oaths. The ALJ may also impose appropriate sanctions for those who do not obey an order made under these procedures. For example, the ALJ may exclude testimony, expel persons from further participation in the hearing, exclude from further participation in the hearing, exclude evidence or refuse to allow a person to assert or oppose designated claims or defenses.

The location of a second tier hearing will be determined by the ALJ. The proceedings will be tape-recorded. Any party may request that the proceedings be transcribed. The ALJ has the power to reconvene a hearing at his/her discretion and limit the length of the hearing.

A copy of the second tier hearing decision will be written and detail the ALJ's reasoning for the decision as well as a statement further explaining the rights to appeal the decision. The decision must be rendered within thirty (30) days of the receipt of the appeal of the "Program Panel's" decision.

After the mailing of the decision of the ALJ the member, provider or agency may appeal the decision of the ALJ to the the Authority's Chief Executive Officer within ten (10) days of the date of receipt of the decision letter. A timely appeal may be commenced by the receipt of a letter of facsimile. The appeal letter shall concisely and fully explain all the reasons for the request. No new evidence may be presented to the Chief Executive Officer. Evidence is confined to the record.

The Chief Executive Officer or his designee may review the matter and he must render a final agency decision within five *(5)* days of the receipt of the appeal. The appeal process for members including tier one, tier two and CEO review will take place within ninety (90) days.

Provider Appeals

Under the waiver, the provider also has a right to appeal to the Authority. The LD-2 is used by the provider to file the appeal. The form must be filed within twenty **(20)** days of the action by the Authority. The Authority anticipates that some of the appeals received

will involve decisions made concerning disenrollment for cause. It is also possible some appeals may be received concerning wrap around services.

In any event a Subchapter 1 proceeding will be given to the provider in the event of an appeal. Once the appeal is received, the case will be assigned to an administrative law judge (ALJ). The hearing conducted by the ALJ will be held in an informal manner without the use of formal rules of evidence or procedure. The ALJ shall have the power to hold prehearing conferences, consider any matter to expedite the hearing, require the parties to state their positions, require the parties to produce relevant witnesses and documents under their control, rule on motions and other procedural matters, regulate the course of hearings, establish time limits for the submission of motions and memoranda, take judicial notice of material facts and administer oaths. The ALJ may also impose appropriate sanctions for those who do not obey an order made under these procedures. For example, the ALJ may exclude testimony, expel persons from further participation in the hearing, exclude from further participation in the hearing, exclude evidence or refuse to allow a person to assert or oppose designated claims or defenses.

The location of the hearing will be determined by the ALJ. The proceedings will be tape-recorded. Any party may request that the proceedings be transcribed. The ALJ has the power to reconvene a hearing at his/her discretion and limit the length of the hearing.

A copy of the decision will be written and detail the ALJ's reasoning for the decision as well as a statement further explaining the rights to appeal the decision. The decision must be rendered within sixty (60) days of the receipt of the appeal.

The decision of the ALJ may be appealed by the provider or the Authority. The appeal must be properly filed with the agency within twenty (20) days of the receipt of the ALJ's decision. This appeal is to the CEO of the Oklahoma Health Care Authority. The appeal must concisely and fully explain the reasons for the request. No new evidence may be presented to the CEO. Evidence presented is confined to a record review. The Authority's CEO or his/her designee will review the matter and make a written decision within forth-five (45) days of the receipt of the appeal.

16. Voluntary Enrollment of Seriously Mentally Ill (SMI) Adults and Seriously Emotionally Disturbed (SED) Children

SMI adults and SED children are exempted from enrollment in SoonerCare health plans (MCOs) during Years I and II of the Program. During these two (2) years, health plans will use a State-developed tool to assess those members whom they believe are SMI/SED. The OHCA Behavioral Health Unit will review the findings of such assessments, and when it concurs, will order the disenrollment of the SMI/SED member from the plan. These individuals will then be served through the traditional fee-for-service Medicaid Program (see Attachment 18 for a copy of the OHCA assessment tool, criteria, and description of the assessment/review procedures).

Beginning with the third (3rd) year of the urban **SoonerCare** Program (July 1, 1997, through June 30, 1998), Medicaid clients who meet the OHCA criteria for having a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) will be given the option to enroll (or remain enrolled) in a health plan, rather than being excluded automatically from managed care. The remainder of this chapter describes the voluntary model for SMI/SED clients, including enrollment/disenrollment procedures, case management requirements, benefit packages, and capitation rates.

Enrollment/Disenrollment

There are two (2) populations who will be affected by the introduction of a voluntary model for SMI/SED clients during Year III:

1. individuals assessed as SMI/SED and disenrolled from health plans in Years I and II; and

2. individuals identified as SMI/SED in Year III.

Procedures for these two populations are outlined separately below.

Individuals Identified in Years I and II

During Years I and II, clients assessed as SMI or SED will be disenrolled from health plans and placed back into the fee-for-service Medicaid Program. Prior to the open enrollment period for Year III, the State will send a letter to all such clients (or guardians) who are still Medicaid-eligible informing them that they have the option to enroll in a health plan for Year III. SMI/SED recipients will be permitted to select different plans from those selected by other family members. Thus, during the open enrollment, the SMI/SED individual who chooses to participate in SoonerCare will be able to select a different plan from family members, join his/her family's existing plan, or the entire family may join another plan. If the SMI/SED individual does not actively choose SoonerCare participation, he or she will remain in the fee-for-service program. The client will not be given another opportunity to enroll in managed care until the next open enrollment period.

Individuals Identified in Year III

Going forward in Year III, health plans will remain responsible for identifying and assessing members who they believe may be SMI or SED. When a health plan makes a positive assessment, and the State concurs, the OHCA will contact the member and offer him/her (or their guardian) the option of remaining in the health plan or disenrolling back to the fee-for-service program. The SMI/SED member will be given thirty (30) days after approval of this status by the OHCA-designated clinician to make a choice. If neither option is chosen, he/she will be left enrolled in the health plan. Following expiration of the thirty (30) day window, SMI/SED members will be governed by the same lock-in and disenrollment procedures as apply to other MCO enrollees.

Case Management/Treatment Plans

Health plans will be required to conduct face-to-face evaluations of all SMVSED enrollees within fifteen (15) days of plan enrollment or SMI/SED determination and develop treatment plans that identify behavioral and physical health services to be furnished to such members. Plans also will be required to establish appropriate case management systems for their SMVSED enrollees, to ensure that treatment plans are implemented in full. The OHCA will evaluate the adequacy of health plan case management systems, both through information collected as part of the Year III procurement, as well as through on-site readiness reviews to be performed at health plans prior to the start of the Year III contract period.

In the case of individuals who were designated SMI/SED in Years I and II of the ***SoonerCare*** Program and who choose to enroll in a health plan for Year III, the plans will also be required to perform a re-assessment of the SMI/SED status/designation. The health plan will be required to perform the (re-)assessment and submit the completed documentation to the OHCA no later than sixty (60) days following the enrollment lock-in date for affected members. If the health plan fails to complete an assessment by that date, or if the assessment finding is negative, beginning the first of the subsequent month, the member will be re-classified as non-SMI/SED, for capitation payment purposes (see below for further information on capitation). If the member/client does meet the criteria for SMI/SED status, such status will remain in effect for the remainder of the contract year.

Benefit Packages

In addition to defining case management standards specific to the SMVSED population, the State also has added a behavioral health benefit package which includes additional services appropriate to the treatment of SMI/SED individuals. The SMI/SED benefit package includes intensive outpatient services, psychosocial rehabilitation services, home-based services, rehabilitative case management, and therapeutic foster care. There are also additions to the Alternative Benefits package which may be helpful in providing for SMI/SED individuals such as in-home support services, peer counseling, mobile crisis assessment, and community-based residential programs. Attachment 19 to the Protocol includes a copy of the base, alternative, and SMI/SED behavioral health benefit packages as will be utilized for the Year III RFP.

Capitation

For Year III, the State will establish separate capitation rates for §MI and **SED** enrollees that will reflect their significantly higher behavioral and physical health costs [there will be separate adult (SMI) and child (SED) rates]. The enhanced rates will be developed through a detailed analysis of historical claims data for clients identified as SMI/SED during the first two (2) years **of** the ***SoonerCare*** Program. The State will provide more detailed information on the methodology employed as part of its overall actuarial methodology submission to HCFA prior to the start **of** Year III.

While the State is confident that the rates to be paid to health plans will be sufficient (without exceeding the upper payment limits). plans ~ s will be given additional protection in the form **of** a "risk **corridor**" to be established around the capitation rates. Specifically, at the end **of** Year **111,** the State will compare the **aggregate** cost of services for SMI/SED members in a health **plan** to the total capitation paid for those members. If the percentage difference is equal to or less than five (5) percent, the plan will bear one-hundred (100) percent of the gain or **loss.** However. if the difference is greater than five (5) percent. the **OHCA** will share in the incremental **gain** or loss **as** follows:

- Portion between five (5) and ten (10) percent: ninety (90) **percent plan/ten (10)** percent OHCA;
- Portion between ten (10) and fifteen (15) percent: fifty (50) **percent plan/fifty (50)** percent OHCA; and
- Portion above fifteen (15) percent: ten (10) percent plan/ninety (90) percent OHCA.

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